MONTANA'S MEDICAID PROGRAM

Prepared for the

Legislative Finance Committee

by

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EXECUTIVE SUMMARY

This is the third in a series of reports on the Montana medicaid program. The first report entitled, Inpatient Psychiatric Treatment for Individuals Under 21, was presented to the Legislative Finance Committee in May. The second report entitled, Medicaid Optional Services, was presented at the committee's August meeting. This report discusses medicaid from a global perspective, including all medicaid expenditures except state institutions' reimbursement and Indian Health Service federal pass-through monies.

During the period 1984 to 1990, Montana's total medicaid expenditures have nearly doubled, increasing from less than $84 million to more than $164 million, at an annual rate of nearly 12 percent. Moreover, during the last year of the period (1989-1990), expenditures increased nearly 17 percent. If this trend continues, Montana's medicaid costs will escalate dramatically during the next biennium.

Available data suggests that the significant increase in Montana's medicaid expenditures have not been due to "medical inflation", i.e., medicaid providers being paid sharply increased rates for providing the same level of service. While there have been some increases in the per unit cost allowed medicaid providers, in most cases the increases have not kept pace with inflation during the period.

The primary factor driving medicaid costs upwards appears to be increased utilization of medicaid services due to: 1) increased numbers of persons becoming eligible for medicaid services; and 2) increased utilization of medicaid services by persons who are eligible. From 1984 through 1990, the number of persons eligible to receive medicaid services increased at an annual rate of 6.41 percent, at a time when the state's population was

declining. Further, available data suggests that an increasing number of persons eligible to receive medicaid services are using a wider variety of medicaid services.

The one exception to these trends is in the area of nursing care. Records show that both number of nursing care recipients and nursing bed days grew at a much slower rate than other medicaid services. From 1985 through 1989, the number of medicaid recipients over age 65 increased 3.47 percent annually, but the number of recipients receiving nursing services increased only 1.27 percent and nursing bed days only 1.62 percent. This trend may indicate that services developed to keep elderly medicaid recipients in their homes, such as personal care and the waiver program, have been relatively successful.

When medicaid expenditures are analyzed on a per recipient cost basis, recipients age 21 and over cost much more than recipients under 21. In recent years, however, the cost per recipient for persons under 21 has increased at a much faster rate than costs per recipients 21 and over. Because more than 50 percent of medicaid recipients are under age 21, rapid increases in per recipient costs for this group will significantly impact medicaid costs in the future.

In comparison with other states in the region, Montana ranked third in total medicaid expenditures per capita and first in the number of medicaid recipients per capita during 1989. Montana was one of only three states in the region providing medicaid services to persons in the "medically" needy category, a category of persons to whom states provide medicaid services at their option.

A comparison of other federal assistance programs among the states in the region suggests Montana may have more persons who fit the "categorically" needy description to whom medicaid services must be

provided. In late 1987, Montana ranked first in the number of AFDC recipients per capita and second in the number of food stamp and SSI recipients per capita. The report explores possible reasons for Montana's large number of recipients per capita.

Issues included in this report are:

ISSUE 1: SHOULD THE STATE REVIEW ITS MEDICAID ELIGIBILITY POLICY FOR THE MEDICALLY NEEDY CATEGORY?

ISSUE 2: SHOULD THE STATE ATTEMPT TO DETERMINE THE REASONS FOR THE LARGE NUMBER OF AFDC RECIPIENTS IN MONTANA COMPARED WITH OTHER STATES?

PURPOSE

The purpose of this report is to provide the Legislative Finance Committee:

1) a discussion of the criteria used by the Montana medicaid program when determining medicaid eligibility;

2) current and historical numbers of Montana residents eligible to receive medicaid services;

3) Montana's current and historical costs of funding the medicaid program;

4) Montana residents' current and historical utilization of medicaid services; and

5) a comparison with other states of Montana's medicaid program costs and recipient utilization;

INTRODUCTION

The medicaid program, authorized under the federal Social Security Act, provides medical assistance for impoverished individuals who are aged, blind, or disabled, and adult and under-age members of families with dependent children.

States must provide "mandatory" medicaid services and may provide "optional" services under the medicaid program. Federal regulations require that states provide a minimum number of medical services (mandatory services) to "categorically" needy individuals. Such individuals are generally those receiving public financial assistance under the Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) programs authorized under the federal Social Security Act. States may, at their option, also reimburse for other medical services provided to the "categorically" needy.

Federal regulations also permit states to provide medicaid services to persons not receiving federally supported financial assistance, if they are determined by the state to be "medically" needy. These individuals would qualify for assistance except that their slightly greater income and/or resources prevent them from receiving public financial assistance. Montana provides both mandatory and optional medicaid services to the "categorically" and "medically" needy.

This report reviews Montana's medicaid program in its entirety. Cost and utilization figures shown in the report include both "mandatory" and "optional" services provided to the "categorically" and "medically" needy unless otherwise noted.

MEDICAID ELIGIBILITY

Eligibility Criteria

Under federal regulations, an individual must meet two "status" criteria to be eligible for medicaid benefits. One status relates to an individual's financial status, the other to the individual's age or physical

condition, or whether the individual has responsibility for dependent children.

Both status conditions must be met before one is eligible for medicaid. For example, an adult may be living in poverty but not be eligible for medicaid unless he/she is responsible for a dependent child. Or an adult may be disabled but not eligible for medicaid if his/her income and assets exceed prescribed limits.

Federal regulations require states to provide medicaid services to persons who are "categorically" needy. Medicaid services to the "medically" needy are provided at the discretion of individual states. To be eligible under either categorically or medically needy provisions, one must meet the conditions of one of the following federal assistance programs: 1) Aid to Families with Dependent Children (AFDC); or 2) Supplemental Security Income (SSI). The only real distinction between the categorically and medically needy is that a categorically needy individual is actually receiving financial assistance through the AFDC or SSI programs, while the medically needy individual's income or assets is slightly higher than prescribed limits for AFDC or SSI payments but still inadequate to pay medical expenses.

Categorically Needy

Federal regulations generally define the categorically needy as persons who are aged, blind, disabled, or families and children who meet the financial eligibility requirements of the AFDC and SSI programs. Individuals who are actually receiving financial assistance under these programs, or children for whom adoption assistance or foster care maintenance payments are made, are automatically eligible for medicaid benefits. Due to the "automatic" nature of medicaid eligibility for the categorically needy, the state's medicaid expenditures bear a direct relationship to the numbers of

persons within the state receiving financial assistance through these federal programs.

The categorically needy are divided into two status categories, SSI and AFDC. The following narrative discusses eligibility criteria for these categories of medicaid recipients and also discusses recent federal expansion of medicaid eligibility in the AFDC area.

1) SSI Persons qualifying for SSI must be over 65 years of age, blind or disabled, and entitled to financial assistance because of lack of income and resources. Montana has little discretion in determining medicaid eligibility under the SSI-related provision of the categorically needy. The federal Social Security Administration establishes income and resource standards which must be met by persons receiving SSI payments. Once a person qualifies for SSI benefits, he/she is also entitled to medicaid benefits.

2) AFDC In contrast, federal regulations allow states much more flexibility in determining medicaid eligibility under the AFDC-related provision of the categorically needy. While the federal government sets the general rules under which the AFDC program operates, decisions concerning income, resource and benefit standards are left to the individual states, as long as those decisions comply with general federal direction. When establishing eligibility for AFDC assistance, a state is at the same time making a decision which will impact the cost of its medicaid program.

Montana administrative rules specify the income and asset levels which must be met before an individual is eligible for AFDC assistance. The rules limit assets to items necessary for day-to-day living, such as $1,500 equity in a vehicle for family transportation, household goods, clothing, and equipment and tools necessary to produce food or secure employment.

The state applies three different standards to determine income limits for AFDC eligibility.

1) The gross monthly income standard limits the amount of gross monthly income (before any deductions are made) an assistance unit can receive before.

2) The net monthly income standard limits the amount of net monthly income an assistance unit can have. This standard is also considered to be the "needs" standard--net income the assistance unit needs for basic subsistence, including food, clothing, shelter, and other essentials.

3) The benefit standard is the actual cash payment the recipient will receive based on the number of adults and dependents in the assistance unit. The benefit amount is currently set by the legislature at 42 percent of the federal poverty index.

Once a person is determined eligible for AFDC assistance and receives a benefit payment, he/she automatically qualifies for medicaid benefits.

Beginning April 1, 1990, the federal government required states to provide medicaid services to pregnant women and infants with family incomes up to 133 percent of the federal poverty level. The 1989 legislature appropriated funding for this group of recipients based on their eligibility at incomes up to 75 percent of the poverty level in 1990 and 100 percent of the poverty level in 1991. The Department of Social and Rehabilitative Services (SRS) has requested an additional $6.09 million, of which $1.71 million is general fund during the 1993 biennium to fund medicaid services to this group.

Medically Needy

Persons who are determined to be medically needy are provided medicaid services at the option of individual states. Federal guidelines define medically needy as persons who: 1) could qualify for financial assistance payments except for their slightly greater income and/or resources; but 2) lack sufficient income and/or resources to pay their medical bills. Persons in this group must still meet AFDC or SSI status criteria, i.e., aged, blind, disabled, dependent child or have responsibility for a dependent child.

Essentially, these individuals have income and/or resources in excess of those that would entitle them to AFDC or SSI payments, but do not have adequate income or resources to provide their basic needs and still pay necessary medical expenses. States choosing to provide medicaid services to this optional group pay a portion or all of their medical expenses. As shown later in this report, a significant amount of Montana's medicaid expenditures for nursing home care are made on behalf of persons who are medically needy.

States providing medicaid services to the medically needy establish income and resource standards within broad guidelines established by federal regulations. If an individual's income or assets exceed the limits set by the state, they are ineligible for medicaid benefits. The same standards apply to both AFDC and SSI-related recipients in the medically needy category.

Current Numbers of Eligibles/Recipients

During state fiscal year 1990, a monthly average of 48,480 Montana residents were eligible to receive medicaid services. Both categorically and medically needy recipients are included in the total.

TABLE 1
FY 1990 Medicaid Eligibles
AFDC/SSI
(Monthly Average)

Type	Number	(%) Total Number	(%) Total Costs
		(%)	(%)
AFDC	34,306	70.76	34.03
SSI	14,174	29.24	65.97
Total	48,480	100.00	100.00

Table 1 shows that while SSI eligibles comprised less than 30 percent of those eligible to receive medicaid services, medicaid expenditures made on behalf of SSI recipients comprised nearly 66 percent of total medicaid expenditures. Detailed expenditure information by eligibility type is shown in Section V.

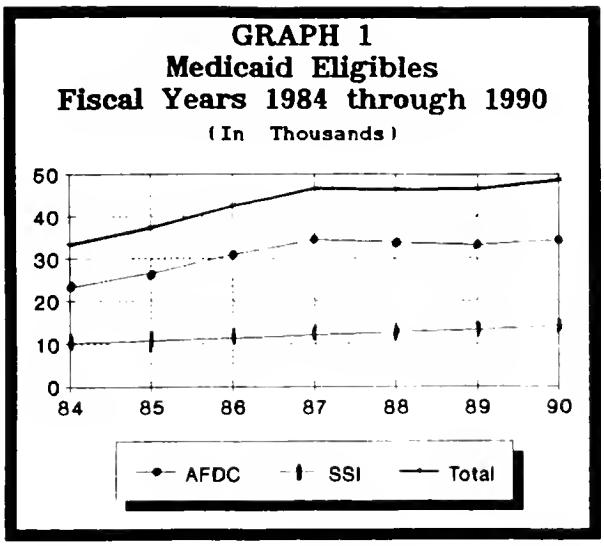
TABLE 2
FY 1990 Medicaid Eligibles
Categorically/Medically Needy
(Monthly Average)

Type	Number	(%) Total Number	(%) Total Costs	(%) Nursing Costs
		(%)	(%)	(%)
Medical	2,977	6.18	21.91	45.07
Categorical	45,483	93.82	78.09	54.93
Total	48,480	100.00	100.00	100.00

Table 2 shows that while the medically needy comprised only 6.18 percent of the total number of persons eligible to receive medicaid services, expenditures made for the medically needy comprised nearly 22 percent of total medicaid expenditures and over 45 percent of nursing care expenditures.

Historical Numbers of Medicaid Eligibles

The monthly average number of persons eligible to receive medicaid services increased from 33,387 in 1984 to 48,480 in 1990, an average annual increase of 6.41 percent. During the same period, the state resident population actually decreased 3.28 percent.



Graph 1 shows that the number of AFDC-related eligibles increased at an annual rate of 6.81 percent during the period, while the number of SSI-related eligibles increased 5.5 percent annually. The number of AFDC eligibles actually declined from 1987 to 1989 but increased again in 1990. The number of SSI eligibles has grown steadily since 1984.

MEDICAID COSTS

Current Costs

Total Costs

Montana's total medicaid expenditures for fiscal 1990 were $164.108 million, of which approximately $47.312 million is state general fund. Table 3 lists state fiscal year 1990 expenditures for the Montana medicaid program by service type in descending order of expenditure. The federal government will fund approximately 71.17 percent of Montana's medicaid benefit expenditures in 1990. Nursing and inpatient hospital services comprised approximately 56 percent of total medicaid expenditures during 1990.

TABLE 3

Montana Medicaid Expenditures
State Fiscal Year 1990[1]

(Millions)

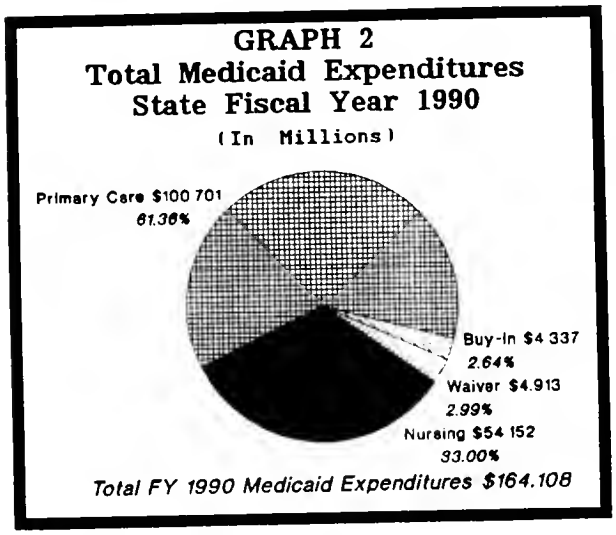
Service Type	Total Spent ($)	General Fund ($)	Percent Of Total (%)
Nursing Facilities	54.152	15.612	33.00
Inpatient Hospital	37.266	10.744	22.71
Physician Services	15.018	4.330	9.15
Prescription Drugs	11.231	3.238	6.84
Inpatient Psychiatric	9.253	2.668	5.64
Outpatient Hospital	8.774	2.530	5.35
Waiver Services	4.913	1.416	2.99
Medicare Buy-In	4.337	1.250	2.64
Clinic Services	4.169	1.202	2.54
Personal Care	3.872	1.116	2.36
Medical Equipment	3.409	.983	2.08
Dental Services	3.065	.884	1.87
Optometrists	.980	.282	.60
Medical Transportation	.586	.169	.36
Psychologists	.541	.156	.33
Home Health Services	.460	.133	.28
Social Workers	.451	.130	.27
Lab & X-Ray Services	.268	.077	.16
Family Planning	.213	.061	.13
Physical Therapists	.211	.061	.13
Podiatrists	.207	.060	.13
Occupational Therapists	.156	.045	.10
Speech Therapists	.153	.044	.09
Hearing Aids	.151	.043	.09
Eyeglasses	.149	.043	.09
Nurse Specialists	.054	.016	.03
Home Dialysis	.037	.011	.02
Audiologists	.029	.008	.02
TOTAL	164.108	47.312	100.00

(1) Projected expenditures through June 30, 1992. (See Appendix)

Services provided under the medicaid program are grouped into four broad categories of services: 1) primary care; 2) nursing care; 3) waiver services; and 4) medicare buy-in. The relatively new waiver program (fiscal 1984) is intended to provide an alternative to nursing home care for the elderly and persons with disabilities. The recipient of waiver services

must be certified as requiring the same level of care as would be provided in a nursing home.

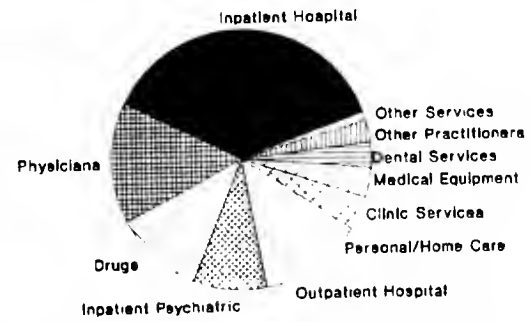
The medicare buy-in program expends medicaid funds to pay medicare Part B premiums for individuals qualifying for medicare, but who are financially unable to pay the premiums. Medical expenses are then purchased for these recipients with 100 percent federal medicare funds, rather than with medicaid funds which require a state match. This program is intended to save state general fund by assuring that medical services provided to persons eligible for both medicaid and medicare are reimbursed with federal medicare funds.



Graph 2 shows that of total medicaid expenditures, primary care comprised 61.36 percent, nursing care accounted for 33 percent, and waiver services and medicare buy-in comprised 2.99 percent and 2.64 percent respectively. There are many different types of services provided in the primary care category as depicted in Graph 3.

Expenditures for inpatient hospital services comprised the largest portion of $100.701 million in total primary care expenditures, followed by physician services, prescription drugs, inpatient psychiatric services, and outpatient hospital services.

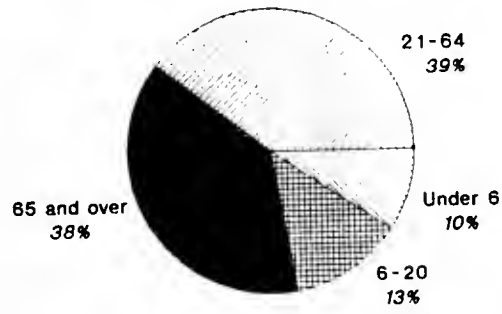
GRAPH 3
Primary Care Expenditures
State Fiscal Year 1990



Total FY 1990 Primary Care Expenditures $100.701

Costs per recipient

GRAPH 4
Total Medicaid Expenditures
By Recipient Age
Federal Fiscal Year 1989
(In Millions)



Federal FY 1989 Medicaid Expenditures $155.926

Graph 4 shows expenditures for recipients 21 and over comprised 77 percent of total expenditures, while expenditures for recipients under 21 comprised only 23 percent. However, over 50 percent of medicaid recipients were under age 21. Per recipient costs are much lower for persons under 21 but costs for this group are increasing faster than any other age group. (See Table 7)

Historical Cost Increases

Total Costs

During the past six years, Montana's medicaid expenditures have nearly doubled, increasing from $83.733 million in 1984 to a projected $164.108 million in 1990.

Graph 5 shows that total medicaid expenditures increased at an annual rate of 11.87 percent, while general fund expenditures increased 6.75 percent annually. Federal funding participation increased from 61.82 percent in 1984 to 71.17 percent in 1990. Medicaid expenditures increased less than 11 percent annually from 1984 through 1989, but increased nearly 17 percent from 1989 to 1990. If this trend continues, medicaid expenditures will increase significantly during the 1993 biennium.

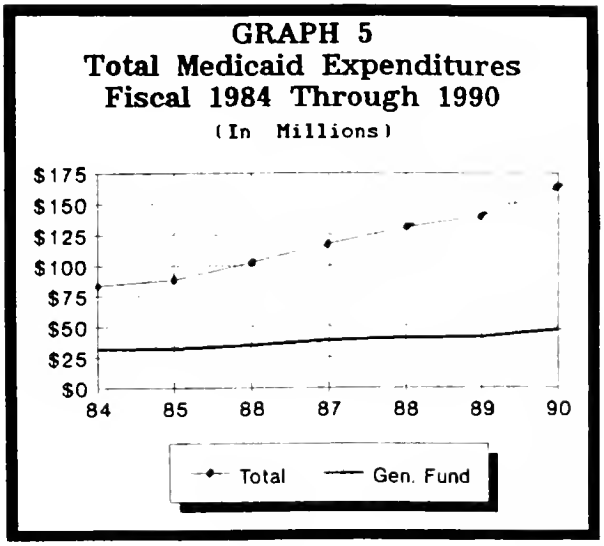


Table 4 shows that expenditures for primary care, which comprises more than 61 percent of total medicaid expenditures, increased much more rapidly than nursing care. The slower growth in nursing care costs may be due to two programs implemented during the period to reduce admissions to nursing homes. Expenditures for the waiver program, a program designed to keep people in their homes rather than in long term nursing care, grew at an annual rate of 104.35 percent during the period. Expenditures for personal care, another program designed to reduce admissions to nursing homes, increased from 0.$92 million in 1986 to $3.87 million in 1990. Personal care expenditures are included in primary care.

TABLE 4
Total Medicaid Expenditures
State Fiscal Years 1984 and 1990
(Millions)

Expenditure Type	Fiscal Year 1984	Fiscal Year 1990	Annual (%) Increase
	($)	($)	(%)
Primary Care	43.370	100.701	15.07
Nursing Care	39.101	54.152	5.58
Medicaid Waiver	.067	4.913	104.35
Medicare Buy-In	1.194	4.337	23.99
TOTAL	83.733	164.108	11.87

Table 5 shows that when inpatient psychiatric expenditures are excluded, primary care expenditures increased 13.24 percent annually during the period. Expenditures for outpatient hospital services increased more rapidly than any other service. Dental services expenditures increased the least at 4.5 percent annually.

TABLE 5
Primary Care Expenditures
State Fiscal Years 1984 and 1990
(Millions)

Service Type	Fiscal Year 1984	Fiscal Year 1990	Annual (%) Increase
	($)	($)	(%)
Inpatient Hosp.	19.024	37.266	11.86
Physician	6.903	15.018	13.83
Other Services	6.775	13.367	11.99
Presc. Drugs	4.707	11.231	15.60
Outpatient Hosp.	2.073	8.774	27.18
Dental	2.354	3.065	4.50
Other Pract.	1.534	2.727	10.06
TOTAL (1)	43.370	91.448	13.24

(1) Does Not Include Inpatient Psychiatric Services

Cost Increases Per Recipient

This section depicts historical cost increases on a per recipient basis.

TABLE 6
Cost Per Recipient
By Eligibility Type
Federal Fiscal Years 1985 and 1989

Eligibility Type	Fiscal Year 1985	Fiscal Year 1989	Annual (%) Increase
	($)	($)	(%)
AFDC	660	1,028	11.70
SSI	4,761	5,627	4.26
Average	1,819	2,270	5.70

Table 6 shows that expenditures for recipients eligible under AFDC provisions increased at more than twice the rate of expenditures for recipients eligible under SSI provisions. While nearly 66 percent of medicaid expenditures are for SSI eligible recipients, over 70 percent of medicaid recipients are AFDC eligible. If the rapid increases in AFDC recipient expenditures continues, medicaid costs will also increase rapidly due to the large number of AFDC recipients.

TABLE 7
Cost Per Recipient
By Age
Federal Fiscal Years 1985 and 1989

Recipient Age	Fiscal Year 1985	Fiscal Year 1989	Annual (%) Increase
	($)	($)	(%)
Under 6	571	1,047	16.36
6-20	553	1,122	19.32
21-64	1,933	2,253	3.91
65 and Over	5,933	6,956	4.05
Average	1,819	2,270	5.70

Contributing to the rapid increase in costs per AFDC recipients is the trend in expenditures for recipients under 21. Table 7 shows the large expenditure increases for this group. The large increase in expenditures for recipients age 6 through 20 may be partially attributable to the introduction of inpatient psychiatric services for this age group in 1987. If the large increases in per recipient expenditures for persons under age 21 continue, total medicaid costs will be significantly impacted. During federal fiscal year 1989, over 50 percent of all medicaid recipients were under 21.

Per Unit Service Cost Increases

Increases in medicaid expenditures during recent years are due to both increased utilization by medicaid recipients and increases in the amounts paid medicaid providers per service unit. As this section shows, in several service categories the actual costs per service unit allowed by medicaid did not keep pace with inflation. Per unit cost comparisons cannot be made in inpatient and outpatient hospital services due to major differences in the way services were recorded in the first two years of the period.

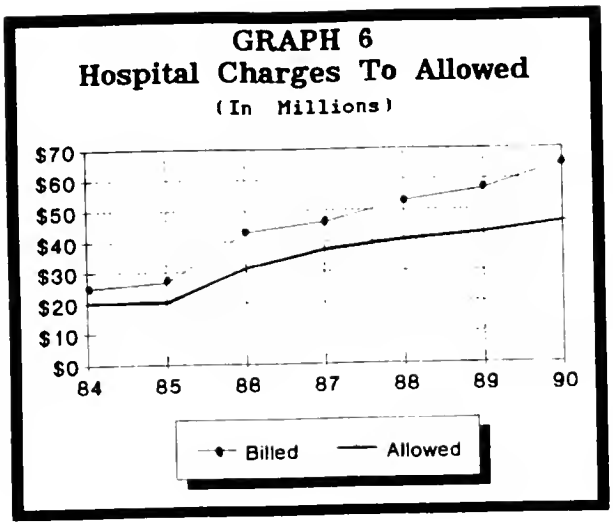
Table 8 shows that the costs allowed by medicaid for most fee-based providers has grown less than inflation during the period. This indicates that the increasing number of persons eligible for medicaid service and increasing utilization by medicaid recipients are the major contributors to the rapid growth in medicaid expenditures.

TABLE 8
Allowed Medicaid Costs
State Fiscal Years 1984 and 1990

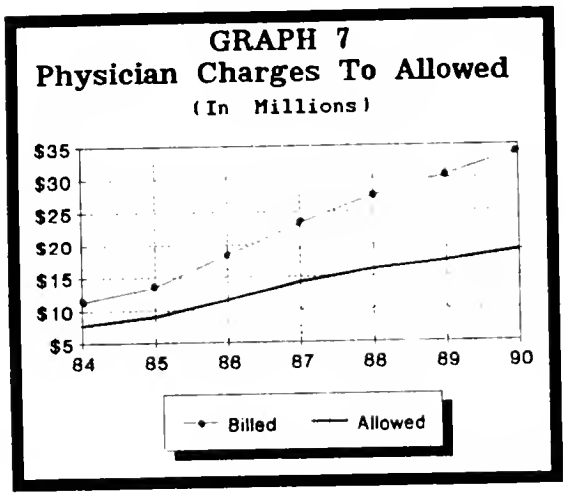
Provider Type	Fiscal 1984 ($)	Fiscal 1990 ($)	Annual (%) Increase (%)
Physician	26.16	29.55	2.05
Other Pract.*	14.05	12.26	-2.25
Drugs	10.64	16.46	7.54
Dentists	23.35	25.76	1.65

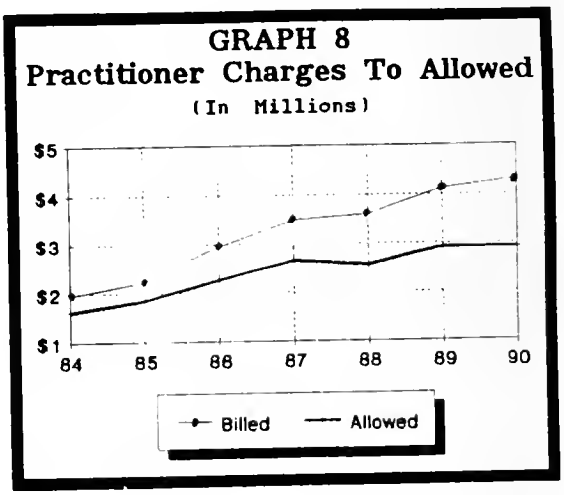
* This category includes eight different professional. A change in the mix of services may affect the overall increase.

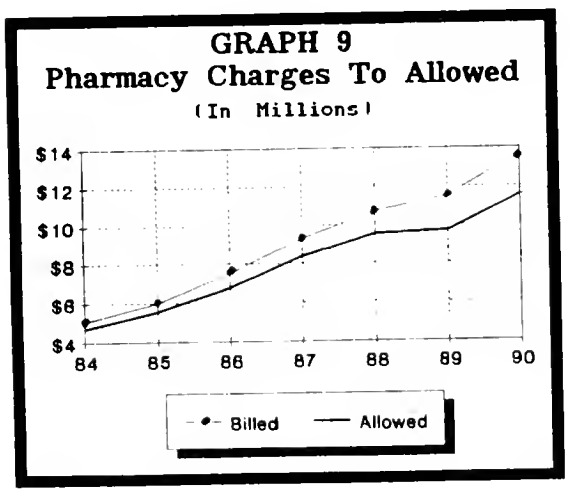
One method which may illustrate how increases in provider reimbursement rates compared to inflation during the period is to compare amounts billed by medicaid providers to the amount allowed by medicaid. Assuming that providers increased their charges to medicaid during the period to reflect increased costs of doing business, such as salaries and malpractice insurance, a widening gap between costs billed and costs allowed would indicate that reimbursement rates have not kept pace with inflation.

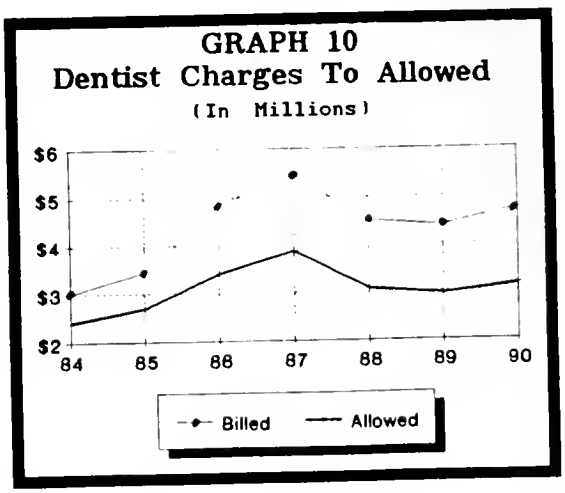


Graphs 6 through 10 depict charges to medicaid by provider types and the costs allowed by medicaid from 1984 through 1990. Allowed costs did not keep pace with provider charges during the period, despite the fee increases granted in 1990.









MEDICAID UTILIZATION

During the period covered by this report, increased use of medicaid services has been primarily responsible for the large increases in medicaid expenditures. There are three factors which determine the number of services for which medicaid reimburses: 1) the total number of persons eligible to receive medicaid services; 2) the number of eligible persons who actually use medicaid services; and 3) the frequency with which individual recipients use medicaid services. This section discusses current medicaid utilization by service category and shows historic increases in medicaid utilization.

Table 15 depicts state fiscal year 1990 medicaid utilization by service category. The average monthly number of recipients, the average monthly number of services provided, and the average number of services per recipient are listed in descending order of recipient numbers.

TABLE 15

Medicaid Recipient/Service Utilization
State Fiscal Year 1990

Service Type	Average Monthly Recipients	Average Monthly Services	Services Per Recipients
Prescription Drugs	21,520	57,719	2.682
Physician Services	18,983	50,374	2.654
Outpatient Hospital	5,411	39,093	7.225
Nursing Care	4,007	114,515	28.576
Dental Services	3,136	9,983	3.183
Inpatient Hospital	1,343	181,789	135.319
Clinic Services	1,320	92,738	70.236
Medical Equipment	1,262	95,146	75.410
Optometrists	1,132	4,163	3.678
Waiver Services	906	55,506	61.260
Personal Care	608	53,130	87.394
Labs/X-Ray Services	597	1,995	3.344
Medical Transportation	427	12,392	29.009
Psychologists	415	4,262	10.272
Social Workers	402	4,521	11.256
Podiatrists	264	819	3.105
Family Planning	262	1,288	4.919
Eyeglasses	203	769	3.792
Home Health	191	1,686	8.832
Inpatient Psychiatric	161	8,818	54.687
Physical Therapy	157	2,128	13.595
Speech Therapy	125	1,736	13.844
Hearing Aids	121	774	6.387
Occupational Therapy	103	1,192	11.524
Audiologists	67	127	1.901
Nurse Specialists	47	119	2.517
Home Dialysis	6	443	76.482
Total	63,176	797,225	
Average			12.619

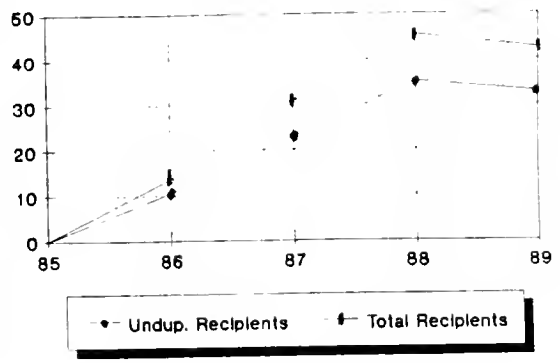
During state fiscal year 1990, more medicaid recipients used physician and pharmacy services than any other services, while the most services were provided in inpatient hospitals, followed by nursing care. The most services per recipient were provided in the inpatient hospital category.

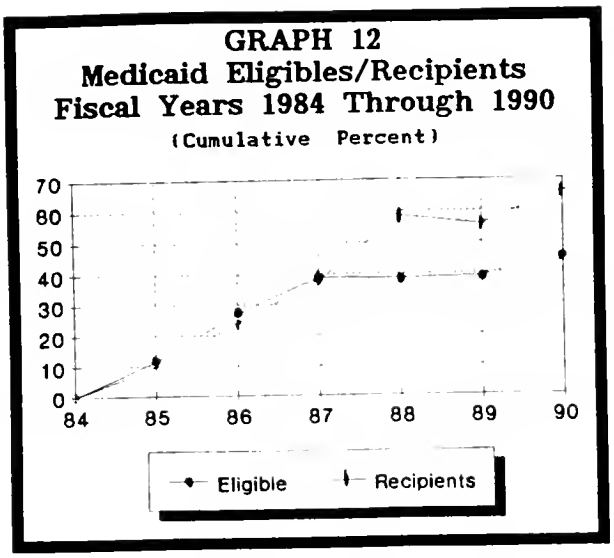
Based on available data, it appears that three trends are increasing medicaid utilization: 1) the first, and most important, is the increasing numbers of persons who are becoming eligible to receive medicaid services;

2) secondly, an increasing number of persons eligible to receive medicaid services are using them; and 3) medicaid recipients are using a wider variety of services available to them.

Graph 11 compares the cumulative percent growth of total unduplicated medicaid recipients to medicaid recipients using services in major service categories. The lower line represents the increase in unduplicated medicaid recipients. The upper line represents the increase in the number of recipients using different medicaid services. This trend indicates that medicaid recipients are using a wider variety of medicaid services available to them.

GRAPH 11
Medicaid Recipient Utilization
Federal Fiscal 1985 Through 1989
(Cumulative Percent)

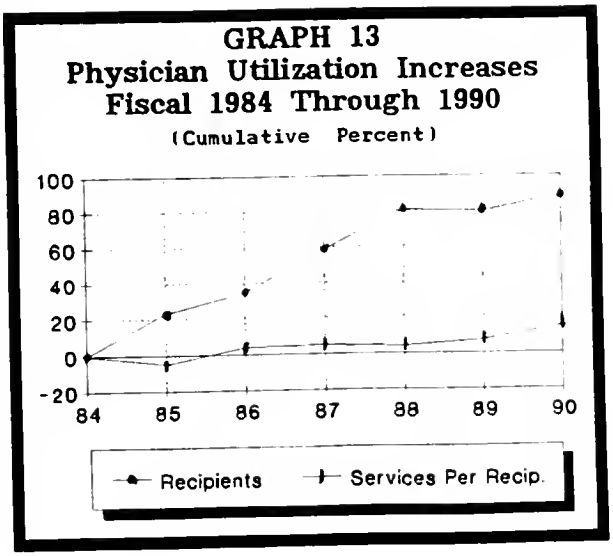


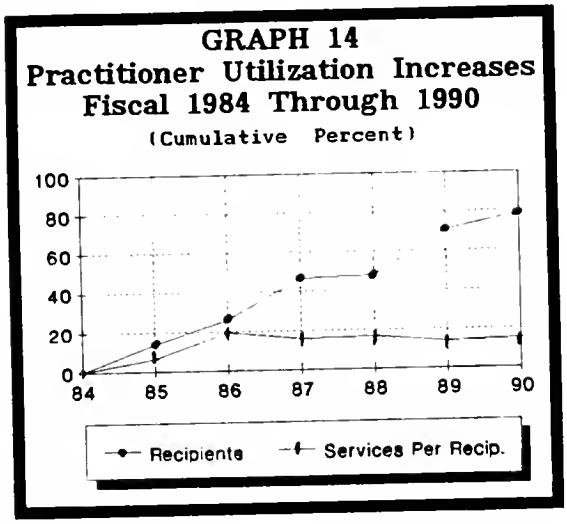


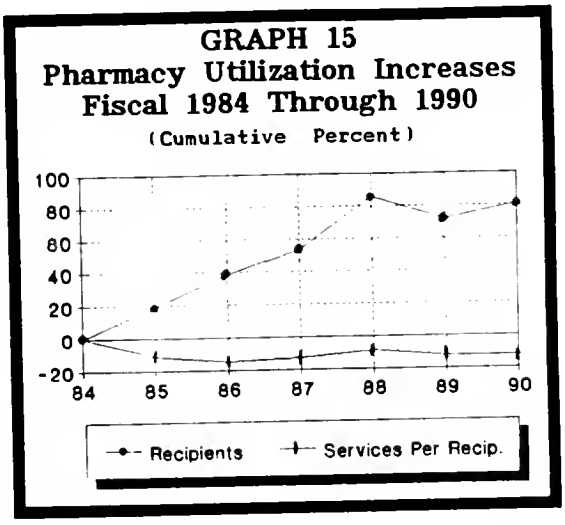
Graph 12 compares cumulative percent growth of the medicaid eligible population to growth of medicaid recipients utilizing services in all service categories. During the period, the medicaid eligible population increased at an annual rate of 6.41 percent, while the number of medicaid recipients utilizing services in all service categories increased 8.82 percent annually. This trend indicates that an increasing number of individuals eligible to receive medicaid services are actually receiving services in a variety of service categories.

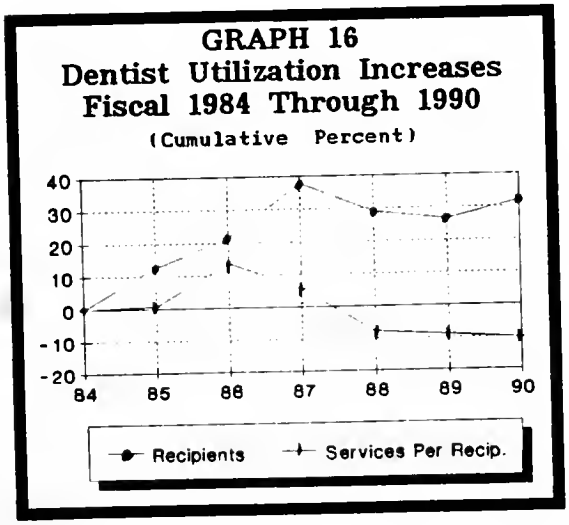
The graphs on the following page illustrate increases in the monthly average number of recipients receiving various services and the monthly average number of services provided per recipient by service category.

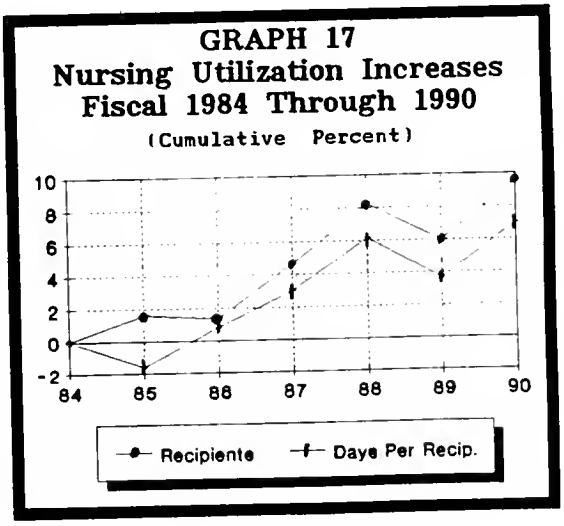
Graphs 13 through 16 compare cumulative percent increases in number of recipients receiving services to average number of services provided per recipient. The number of recipients receiving services increased more rapidly than the number of services provided to each recipient.











The preceding graphs indicate that medicaid utilization increases have occurred because an increasing number of recipients are using medicaid services, rather than individual recipients using the same service more frequently. In two major service areas, services per unduplicated recipient have actually decreased. Based on reports submitted by SRS to the federal government, the average length of stay for medicaid recipients discharged from inpatient hospitals decreased from 4.97 days in federal fiscal year 1985 to 4.67 days in 1989, and the number of prescriptions filled per unduplicated recipient actually decreased.

The reports also show that during the same period, the number of nursing bed days per unduplicated nursing home recipient increased less than one percent annually.

COMPARISONS TO OTHER STATES

This section compares Montana medicaid expenditures to medicaid expenditures in other states in the Denver region of the Federal Health Care Financing Administration (HCFA) and to Idaho, which is in the Seattle region. Expenditures include both state and federal expenditures for each state as reported to the federal government.

Because each state establishes the rates it pays medicaid providers, expenditure comparisons may be significantly impacted by differences in provider rates between states. (For example, Colorado's 1988 average daily hospital room charge was nearly 18 percent higher than Montana's.) To assure that medicaid utilization is also considered when comparing medicaid programs, Table 10 compares not only medicaid expenditures but the number of unduplicated medicaid recipients during the year as well.

Table 10 shows that Montana ranked third in the region in medicaid expenditures per capita during 1989, but ranked first in the number of unduplicated medicaid recipients per 1,000 population. Montana's per capita medicaid expenditures were 128.38 percent of the regional average, and the number of medicaid recipients per 1,000 population in Montana was 129.65 percent of the regional average.

TABLE 10
Medicaid Comparisons
Federal Fiscal Year 1989

State	($) Per Capita	Recip. Per 1,000
N.Dakota *	268.46	70.05
S.Dakota	201.98	62.89
Montana *	191.58	75.56
Colorado	133.29	56.24
Idaho	132.66	46.33
Utah *	115.01	53.88
Wyoming	109.45	61.69
Average	149.23	58.28

*Includes Medically Needy

The reasons for Montana's high ranking relative to other states in the region are not immediately obvious. One possible reason may be the medically needy program. Only three states in the region provided medicaid services to the medically needy, a decision that effects the number of medicaid eligibles and expenditures. Yet, Utah, which provided medicaid services to the medically needy and provides one more optional service than Montana, ranked sixth in both per capita medicaid expenditures and recipients during federal fiscal year 1990. In contrast, South Dakota did not provide medicaid services to the medically needy and provided four fewer optional services than Montana, but yet spent more per capita than Montana.

The medicaid program as authorized under flexible federal regulations, is much too complex to permit a point-by-point comparison between states: 1) provider rates and eligibility criteria may vary significantly; 2) services to the medically needy are provided in some states and not others; 3) states

provide different numbers of optional medicaid services; and 4) some states may provide certain medicaid services but restrict or limit their use.

However, it may be meaningful to compare the relative numbers of persons residing in each state who qualify for financial assistance under other federal programs. Because persons in this group comprise the basic "pool" of medicaid applicants, the relative number of persons in this pool will have a significant impact on a state's medicaid expenditures when compared with other states.

TABLE 11
1987 Federal Financial Assistance Recipients
(Per 1,000)

State	AFDC	SSI	Food Stamps
Montana	35.85	10.51	70.46
Colorado	28.52	9.95	58.25
Wyoming	26.53	5.31	53.06
Utah	26.19	5.89	50.60
S. Dakota	25.39	12.83	71.93
N. Dakota	22.32	10.42	50.60
Idaho	18.04	9.02	58.12
Average	26.69	9.12	58.12

AFDC/SSI as of December, 1987
Food Stamps as of September, 1987

Table 11 compares the number of AFDC, SSI, and food stamp recipients by states within the region during 1987, the most recent year data is available. At the time these numbers were compiled, Montana ranked first in the number of AFDC recipients per capita and ranked second in SSI and food stamp recipients per capita. Montana's AFDC recipient count was 134 percent of the regional average, while its SSI and food stamp recipient counts were 115 percent and 121 percent respectively. Montana was clearly above the regional average in all three categories of recipients receiving federal assistance.

ISSUES AND OPTIONS

Montana's medicaid expenditures increased 11.87 percent annually from state fiscal year 1984 through 1990. However, the average increase during the period does not provide the total picture. Between 1984 and 1989, medicaid expenditures increased at an annual rate of less than 11 percent. But from 1989 to 1990, medicaid expenditures increased nearly 17 percent. This trend, should it continue, will sharply increase medicaid expenditures during the 1993 biennium.

Available data suggests that the rapid increase in Montana's medicaid expenditures is not due to "medical inflation", i.e., medicaid providers receiving large increases each year for providing the same level of service. In fact, in several major service categories, costs allowed by medicaid per service unit have not kept pace with inflation. SRS is requesting additional funding for the 1993 biennium to increase provider rates in several service categories.

The primary factor impacting Montana's medicaid expenditures is the rapid growth in the number of persons eligible to receive medicaid services. During the period 1984 to 1990, the number of persons eligible to receive medicaid services increased 6.41 percent annually, while the state's resident population actually declined. If medicaid costs are to be contained, the steady growth in persons eligible to receive medicaid services must be slowed. Controlling individual medicaid recipient utilization of medicaid services through enhanced utilization review will only partially address the rapid increase in medicaid costs as long as the "pool" of persons entitled to receive medicaid services continues to grow at its present pace.

During federal fiscal year 1989, Montana provided medicaid services to more recipients per capita than any other state in the region. While a

point-by-point comparison of Montana's medicaid eligibility criteria with other states is not possible at this time, there are at least two areas of medicaid eligibility which the legislature may wish to review.

Medically Needy

Montana provides medicaid services to the "medically" needy, a group of recipients to whom the federal government does not require states to provide services. Fiscal 1990 expenditures for this group were $35.95 million, of which $24.38 million was for nursing care. While it may be difficult to make any significant reductions in the number of medically needy recipients residing in nursing homes, there may be actions that can be taken to reduce eligibility and costs in other recipient/service categories.

The fact that four of seven states in the region do not provide medicaid services to the "medically" needy may indicate that it is possible for Montana to reduce the number of persons receiving medicaid services under the medically needy provision of federal regulations.

AFDC Eligibility Criteria

The federal government allows individual states considerable flexibility in establishing eligibility criteria for the AFDC program. Once a person becomes eligible for AFDC financial assistance, he/she is also eligible to receive medicaid services.

During December 1987, Montana had far more AFDC recipients per capita than any other state in the region--nearly twice as many as Idaho (see Table 11). It is difficult to pinpoint the reasons for the relatively large number of AFDC recipients in Montana. Obviously, economic condition and unemployment rates impact AFDC recipient numbers. However, Utah had far fewer AFDC recipients per capita in 1987 than Montana even though

its per capita income was considerably lower. Further, Idaho's unemployment rate was higher than Montana's but it ranked last in the region in numbers of AFDC recipients per capita. Demographic factors may also be part of the reason--Montana may have relatively more single parent families and dependent children residing in the state.

However, the way Montana administers the AFDC program may also increase the number of AFDC recipients. Federal rules allow states considerable flexibility in determining eligibility criteria for the AFDC program. If Montana's AFDC income and asset eligibility criteria are more liberal than other states within the region, or if Montana chooses to provide optional AFDC assistance which other states do not, its AFDC recipient numbers may be higher.

For example, in 1987, Montana was the only state in the region offering the optional "unemployed parent" program, a program designed to provide AFDC assistance to parents who are employed less than 100 hours a month. During 1988, more than 11 percent of Montana's average monthly AFDC caseload was comprised of unemployed parents, who would also have been eligible for medicaid benefits. Beginning in 1990, the federal government requires all states to offer this program for at least six months.

There may be a direct correlation between the fact that Montana ranked first in the region in the number of both AFDC and medicaid recipients. Nearly 71 percent of Montana's medicaid eligible population are eligible under the AFDC provision of the medicaid program.

ISSUE 1: SHOULD THE STATE REVIEW ITS MEDICAID ELIGIBILITY POLICY FOR THE MEDICALLY NEEDY CATEGORY?

Option A: Request that SRS, by January 17, review the state's eligibility criteria for the medically needy to determine if the number of recipients eligible under this provision can be reduced and report its findings to the appropriate legislative subcommittee.

Option B: Take no action.

ISSUE 2: SHOULD THE STATE ATTEMPT TO DETERMINE THE REASONS FOR THE LARGE NUMBER OF AFDC RECIPIENTS IN MONTANA COMPARED WITH OTHER STATES?

Option A: Request that SRS, by January 17: 1) compare Montana's current AFDC recipient population with other states in the region to determine if there is still a large disparity in AFDC recipients numbers; and 2) if so, determine why the disparity exists and report its findings to the appropriate legislative subcommittee.

Option B: Take no action.

APPENDIX

Reporting Systems Used

The medicaid expenditure and recipient information used in this report has been obtained from two different reporting systems developed for different purposes. Both reporting systems use medicaid expenditure and recipient information from one common data base, but the time frames and expenditure/recipient accounting methods are so different that the information cannot be used together in one table or graph. The major differences in the two reporting systems are described below.

1) Reporting system one is based on a state fiscal year time frame (July 1 to June 30) and utilizes the state's accrual accounting system, i.e., expenditures are charged against the year in which the services are provided rather than the year in which the expenditure is made. The medicaid "books" are essentially left open for a period of two years after the end of each fiscal year, during which time payments are made for services provided during the year which has ended. At the end of each fiscal year, the Department of Social and Rehabilitative Services (SRS) "accrues" the amount it believes it will have to pay during the next two years for services rendered during the year just completed.

This reporting system does not provide an unduplicated count of medicaid recipients by service category during the year. Instead, recipients are counted each month in each major service category in which they receive a service, i.e., inpatient, physician, drugs, etc. For example, a medicaid recipient who fills a prescription each month will be counted 12 times during the year. If the same recipient also visits a physician each month, he/she will be counted 12 more times. Theoretically, a medicaid recipient receiving

one unit of service in each service category each month could be counted as many as 132 times per year (12 months times 11 service categories).

The methodology used to count recipients in this reporting system does not permit a determination of growth in numbers of unduplicated medicaid recipients over a period of time. One can not be sure that an increase in recorded number of recipients in this system is due to additional recipients, or the same number of recipients using more services on a monthly basis. When unduplicated recipient counts are used throughout this report, they are obtained from a second reporting system described below.

2) Reporting system two is based on the federal fiscal year (October 1 through September 30) rather than the state fiscal year. It utilizes a "cash" accounting system rather than an "accrual" system, i.e., expenditures are recorded against the year in which the expenditures are made rather than the year in which the services were provided.

The recipient counts used in this system are unduplicated, both in total and by service category. For example, one part of the report records each medicaid recipient only once during the federal fiscal year, despite the number of times he/she receives a different service, i.e., drugs, physicians, etc. However, the report also records each medicaid recipient once each year in each category of service in which the recipient receives a service during the year. This methodology permits both an unduplicated count of total medicaid recipients and an unduplicated count of medicaid recipients in each major service category during the year.

Information from both reporting systems is used in this report but is never combined in a conflicting manner. When this report refers to "state" fiscal year, the information has been obtained from reporting system one. When "federal" fiscal year is referenced, the information is from reporting system two.

Information used to compare Montana's medicaid program with programs in other states was compiled by HCFA from reports submitted by individual states for federal fiscal year 1989. Expenditure and recipient data are based on expenditures made in 1989 without regard to the year in which the service was provided. Population data were obtained from the 1989 Statistical Abstract of the United States published by the United States Bureau of the Census. States are listed in descending order of per capita expenditures.

Costs Not Included in Report

The following costs are not included in this report:

1) Medicaid reimbursement for state-operated institutions: The federal medicaid match received by the state for state institutions reimbursement is actually deposited as revenue in the state general fund, thereby reducing the general fund costs of operating the state institutions. Using these expenditures in this report would overstate Montana's actual costs for providing medicaid services by recording as an expenditure monies which are actually revenues to the general fund. However, in the section of the report which compares Montana's medicaid program with medicaid programs in other states, institutional reimbursement has been included to ensure a fair comparison between states.

2) Indian health pass-through expenditures: As the federally designated state agency responsible for administering the medicaid program, the Department of Social and Rehabilitative Services (SRS) passes through 100 percent federal funds to the Bureau of Indian Affairs to support a variety of health services on Indian reservations located in Montana. This program does not obligate the state general fund

3) State medical expenditures: This program is funded entirely by the state general fund and administered under state, rather than federal rules.

STATE OF MONTANA
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TERESA OLCOTT COHEA
LEGISLATIVE FISCAL ANALYST

October 1, 1990

TO: Legislative Finance Committee

FROM: Carroll South
Senior Fiscal Analyst

SUBJECT: SRS Reports

Attached is a report prepared by the Department of Social and Rehabilitation Services (SRS) discussing options for reducing the scope and cost of the State Medical Program. The report was requested by the committee at its August meeting. SRS' budget request for the 1993 biennium reduces expenditures for the State Medical Program by approximately $7.4 million.

We have also received from SRS the report discussing the limitation of services provided under the medicaid program as required by the 1989 legislature:

> It is the intent of the legislature that the Department of Social and Rehabilitation Services study the issue of limiting services provided under the medicaid program through a definition of services that would restrict services to those services medically necessary to prevent significant illness, to alleviate severe pain, to protect life, or to prevent significant disability. The department is further directed to prepare a written report to the legislature and present the report to the Legislative Finance Committee by September 1, 1990.

Because the report is so large, it is not being mailed to you but will be presented by SRS at the October meeting.

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Review of The
STATE MEDICAL PROGRAM

Department of Social and Rehabilitation Services
Julia E. Robinson, Director

I. BACKGROUND

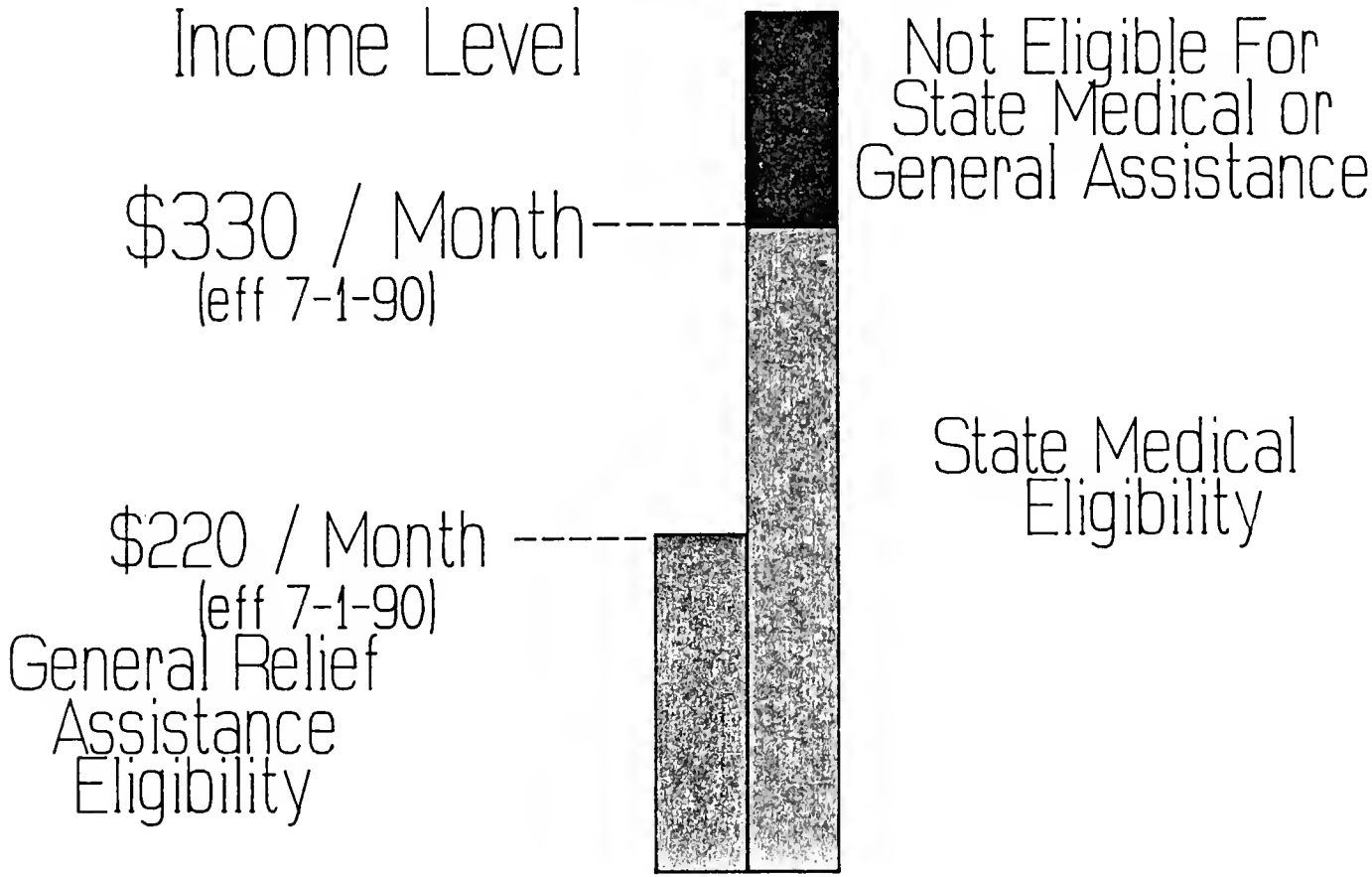
As part of the fiscal 1984 state assumption of county welfare programs, the Department of Social and Rehabilitation Services assumed responsibility for administration and funding of the State Medical Program. This program provides medical assistance to low income persons in the 12 state assumed counties who do not meet eligibility requirements for any other state or federally funded program such as medicaid or medicare. Services provided under the State Medical program are similar in amount, scope and duration to services available through the Medicaid program.

Eligibility criteria for the State Medical program depend on whether or not the applicant also qualifies for cash assistance under the General Assistance program. If the applicant qualifies for a cash payment under the General Assistance program, the applicant automatically qualifies for State Medical benefits. Income and resource criteria used to establish eligibility for General Assistance program are set by the legislature. During fiscal 1991, the maximum income a single person can receive and remain eligible for General Assistance (and therefore also automatically qualify for state Medical benefits) is $220 per month.

A second group of State Medical recipients are individuals who do not meet the income criteria to qualify for General Assistance but who still are in need of medical assistance. For this group, eligibility for State Medical benefits is based on a 12-month prospective income test which takes into consideration "reasonable anticipation" of the individual's ability to work and/or receive income from other sources. Any excess resources must be applied toward the recipient's medical bills. Income eligibility criteria for this group is also set by the legislature. During fiscal 1991, the maximum income a single person can receive and remain eligible for State Medical benefits is $330 per month.

Graph 1 shows differences in income related eligibility criteria for individuals receiving State Medical benefits as a result of qualifying for General Assistance and individuals who can only qualify for the State Medical program.

Graph 1
State Medical Eligibility



Income standards shown are for single person cases.

II. STATE MEDICAL EXPENDITURES

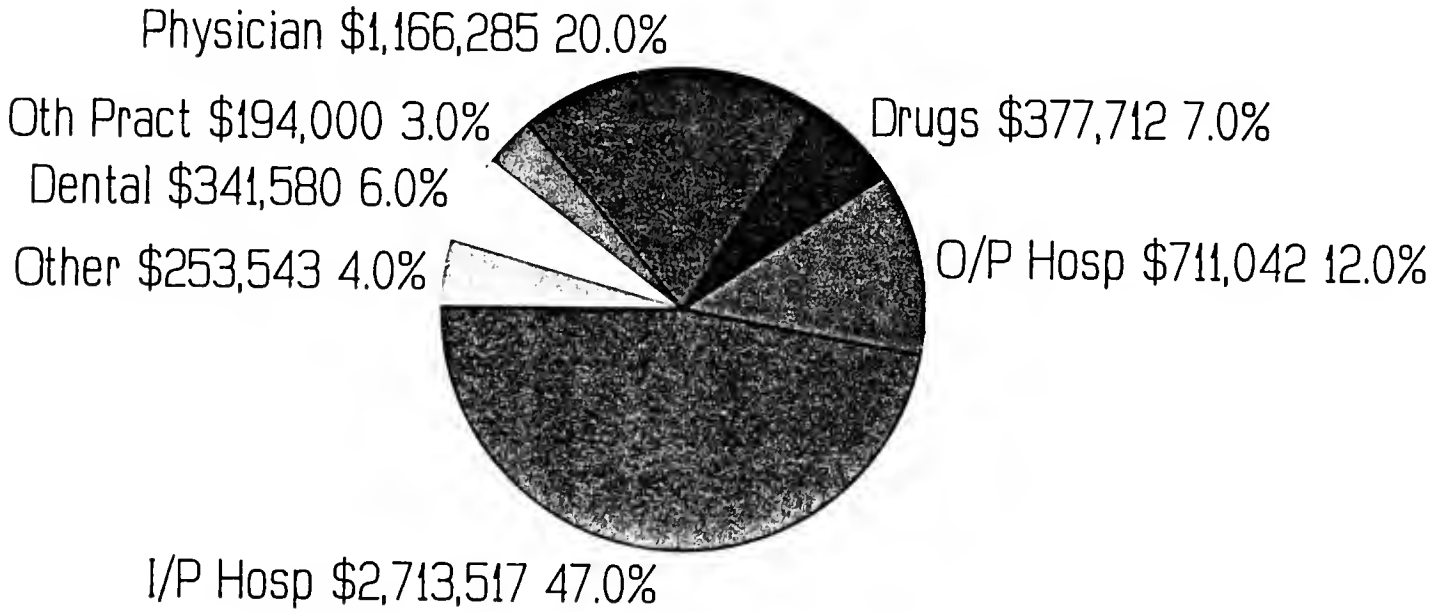
Expenditures for the State Medical program in fiscal 1990 were approximately $5.7 million. Graph 2 shows the distribution of State Medical costs by major expenditure category. As may be seen from Graph 2, inpatient hospital services accounted for approximately $2.7 million or 47 percent of total costs while outpatient services accounted $.7 million or 12 percent. Physician services accounted for $1.2 million or 20 percent of total expenditures. Combined, hospital based services and physician services accounted for approximately 80 percent of total expenditures for the State Medical program. The remaining 20 percent of total expenditures include all drugs, dental services, other practitioners, and other services such as transportation, eyeglasses, hearing aids, etc.

Graph 3 presents an analysis of the distribution of State Medical cases by eligibility group. During fiscal 1990, General Assistance recipients (who are automatically eligible for State Medical benefits) accounted for approximately $4.3 million or 76 percent of the total State Medical expenditures. Of the $4.3 million spent for General Assistance recipients, $2.6 million or 60 percent were for services to recipients who had been determined to be unemployable under the new eligibility rules for the General Assistance program. Unemployable persons include those who are 55 or older with limited work ability, and those who are temporarily or permanently disabled.

The above statistics suggest a strong relationship exists between the size of the General Assistance caseload and expenditures for the State Medical program. It might be assumed that cost associated with the State Medical program would decline at a commensurate rate with the reduction of General Assistance caseloads. However, monthly State Medical costs during fiscal 1990 have remained at approximately the same level as fiscal 1989 costs despite the fact that the General Assistance caseload has been reduced by half. Graph 4 shows the relationship between expenditures for the State Medical program and the General Assistance caseload from fiscal 1987 through March of fiscal 1990. As shown in Graph 4, the General Assistance case load has declined dramatically from a high of 2,103 during 1989 to 745 in June 1990 or a 65 percent reduction in the caseload. During this same period, expenditures for the State Medical program have remained fairly stable at an average expenditure of $447,200 per month.

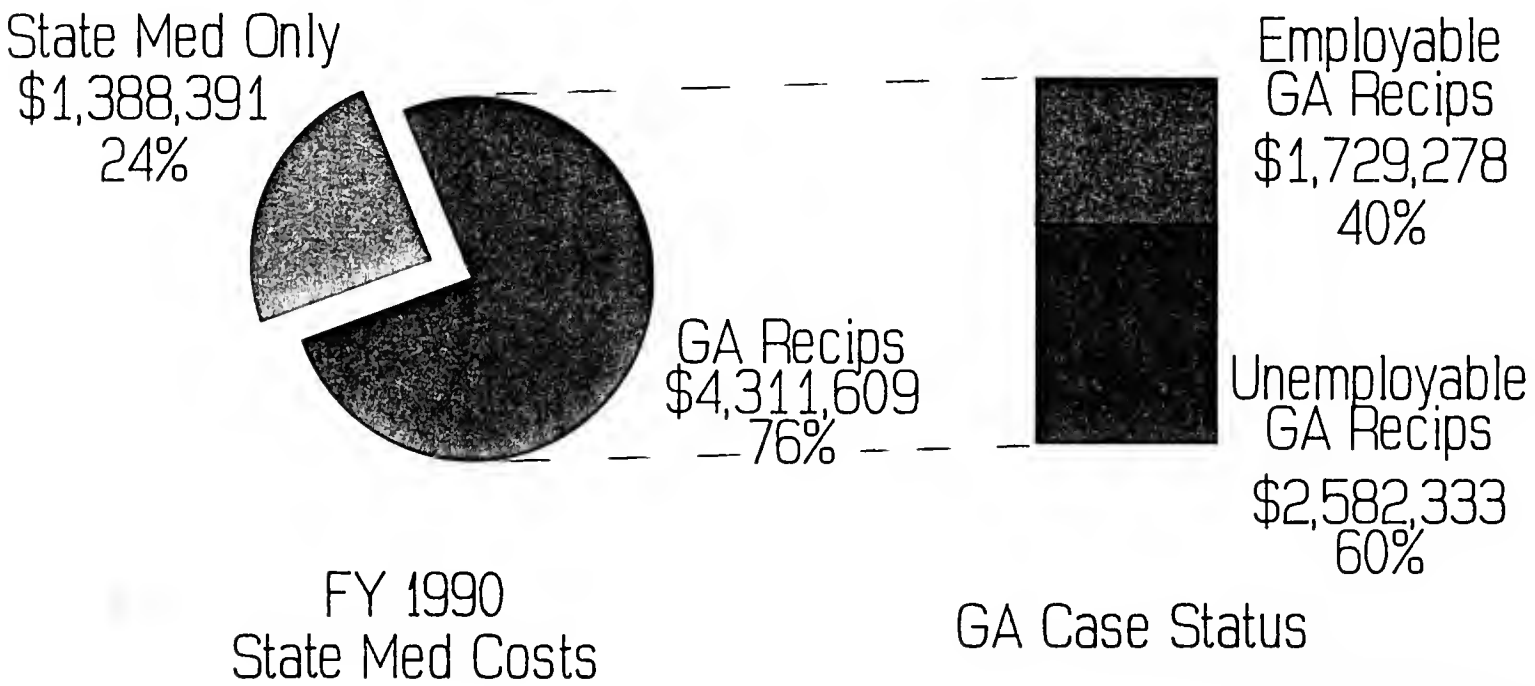
The Department believes that reductions in the cost of the State Medical program are possible through implementation of the cost containment strategies outlined in Alternative One below. However, while some reductions may be possible in the 60 percent of expenditures going towards the disabled, the majority of savings will result from more efficient management of that portion of the program targeted at the 40 percent identified as able bodied. However, to achieve substantial savings in the State Medical program will ultimately require legislative action.

Graph 2
State Medical Expenditures
FY 1989



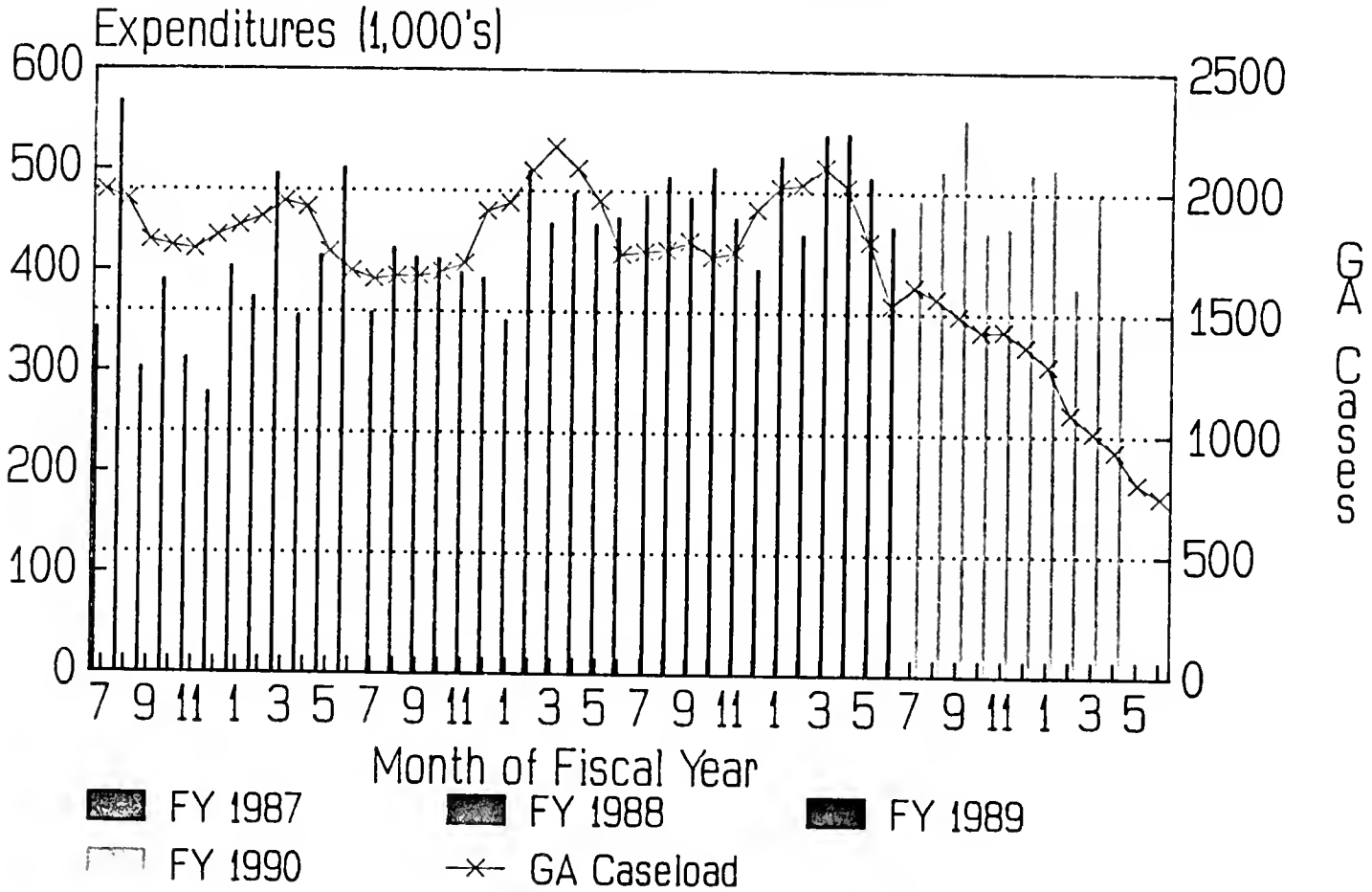
FY 89 Total: $5.7 million

Graph 3
State Medical Costs
From GA Caseload



Total State Medical Costs $5.7 million

Graph 4
State Medical Recipients



FY 1990 Recipient data not complete.

III. COMPARISON OF THE STATE MEDICAL PROGRAM AND NON-ASSUMED COUNTY MEDICAL PROGRAMS

As presented by the Legislative Fiscal Analyst in a report to the Legislative Finance Committee dated August 3, 1990, the per capita cost for the State Medical program administered in the 12 state assumed counties was $14.69 during fiscal 1989. In comparison, the per capita cost to operate the county medical program in Yellowstone and Gallatin counties was calculated at $2.47 and $1.48 respectively. Although there are significant differences in how county welfare programs are administered in the various non-assumed counties, the Department has attempted to compare program structure to identify the major causes of the cost difference between state assumed and non assumed counties.

The chart below presents a comparison of major components of the County Medical programs.

Comparison of State Medical and County Medical Programs

	INCOME SPEND DOWN REQUIRED?	PRIOR AUTHORI-ZATION BY SERVICE?	ALL MEDICAID SERVICES OFFERED?	COLLEGE STUDENTS ELIGIBLE?	NEGOTIATE PROVIDER RATES?
STATE-ASSUMED	NO	NO[2]	YES	YES	NO
YELLOWSTONE	NO	YES	YES	YES	NO
GALLATIN	YES	YES	YES[3]	NO	YES
BALANCE [1]	YES (22)	YES (28)	YES[4] (16)	YES[5] (4)	YES[6] (7)

1. Balance of non assumed counties: 28 Responses; 14 No response.
2. As of September 1, 1990, prior authorization by month has been implemented in the state assumed counties but not by medical necessity.
3. Medicaid amount, scope, and duration - except no alcohol or drug detoxification.
4. In 12 county medical plans, minimum basic services provided. Additional services require county director or county board approval.
5. In 24 counties, the county medical applicant must have been available for work.
6. In 21 counties, the Medicaid approved rate is paid.

IV. CONTROLLING STATE MEDICAL EXPENDITURES

In an effort to control increasing State Medical costs while maintaining essential medical services to those most in need, the department is exploring three alternatives to the current State Medical program. However, due to the complexity of the overall health care system, it is extremely difficult to accurately predict the eventual savings that may result as a consequence of the proposed changes. Such factors as cost shifting, the potential substitution of less costly preventive services for inpatient care, high health care inflation rates, and unanticipated administrative costs may all reduce any future savings. Additionally, reductions in services may result in court challenges that could delay or even prevent implementation of some proposed changes to the program.

Alternative One - Administrative/Management Controls

The department is currently implementing several procedural changes to the administration and management of the State Medical program. Three major areas of change include selective authorization, enhanced utilization review, and managed care.

a. **SELECTIVE AUTHORIZATION:** In the past, all applicants for General Assistance automatically received authorization for State Medical benefits at the same time they were approved for General Assistance payments irrespective of any indication of need for medical assistance by the applicant. Effective September 1990, authorization for State Medical benefits only occurs when specifically requested by the applicant and authorization for benefits is limited to one month.

b. **UTILIZATION REVIEW:** The department has had considerable success in containing costs and reducing abuses of the medicaid program by monitoring recipient utilization. This process involves staff review of paid claim reports to identify possible misuse or abuse. Physician and pharmacy providers are contacted to obtain input on the recipient's treatment. Information is sent to recipients notifying them that their use of medical services is being monitored. The recipient is restricted to specified physician and pharmacy providers if over-utilization continues. Effective September 1990 these utilization review procedures will be applied to state medical cases.

c. **MANAGED CARE:** Managed care is another mechanism for providing recipients with a more cost-effective means of utilizing health care services. Managed care involves monitoring the quality of treatment and determining whether it is appropriate for the recipient's condition. By January 1, 1991, the department plans to contract with a professional health care agency to assess the recipient's need for care and help arrange for the care to be provided in the most appropriate and cost-effective manner possible. Medical

providers will need to obtain approval from the managed care contractor before a proposed course of treatment would be authorized for reimbursement. This will ensure that only medically necessary services are approved for payment. The managed care contract is estimated to save $1,230,000 a year. Estimated savings are based on other state's experience which has resulted in a 30-40% reduction in program costs.

Total potential savings through implementation of all of the provisions of Alternative One may be as high as $2.4 million over the biennium. However, without some experience, savings are difficult to project and could be significantly less.

Alternative Two - Implement Alternative Coverage Programs

This alternative would replace the current State Medical program with two distinct health care programs that target different populations. Under both programs, the state would contract for a strong managed care component.

b) **CHRONIC COVERAGE PLAN:** To qualify for this program, a person would have to meet income and resource eligibility criteria similar to the current State Medical program and:

1. have a severe medical condition which is expected to last at least 12 months, and

2. be actively working to secure Supplemental Security Income (SSI) from the Social Security Administration.

Services provided under this plan would be equal in amount, scope, and duration to medical services provided through the Medicaid program. Prior authorization for services would be coordinated by the managed care contractor to ensure all services requested were medically necessary before any service was provided.

b) **ACUTE COVERAGE PLAN:** As with the Chronic Coverage Plan, all recipients would have to meet income and resources eligibility criteria similar to the current State Medical program. However, the focus of the Acute Coverage plan would be to provide only the essential medical services necessary to alleviate a specific acute medical emergency. Services provided would be limited to physician, hospital and prescription drugs. The amount of payment would be subject to the same restrictions that apply to the Medicaid Program. Prior authorization would also be coordinated through the managed care contractor to determine if the service requested was medically necessary.

Alternative Three - Limit State Medical To Catastrophic Care

The third alternative would limit the services provided under the State Medical program to In-patient hospital, physician services

while in the hospital, and prescription drugs. Under this alternative services would only be available to recipients with the most serious of medical needs. Again, income and resource criteria similar to the current State Medical program would need to be met and a strong managed care component would be built into the program for prior authorization.

While this alternative may not be the option of choice of the Department, it may be necessary to produce any substantial reduction in expenditures for the State Medical program. Preliminary analysis indicates a potential savings of approximately $2.0 million per year if services were restricted as described under this option.

Although the Department has statutory authority to implement the provisions of Alternative One, Alternatives Two and Three represent a significant change in the purpose and direction of the current State Medical program and would require legislative action to implement. Additionally, despite changes to Montana's constitutional provision pertaining to welfare, any change in medical assistance to low income persons would need to be evaluated to ensure that it does not violate the "equal protection" provisions of our state and federal constitutions.

Alternatives Two and Three could impact the General Assistance recipient who is temporarily disabled, or who is employable but has a medical need for vision, dental or hearing care. The Department believes that persons who need those services to <u>obtain</u> work should be able to get them. Therefore, we also propose that those services be available through the Project Work Program (PWP) as part of the General Assistance program. If the person's employability plan specified that any of those services were required to become employable, then payment could be made.

V. OTHER OPTIONS TO REDUCE STATE MEDICAL EXPENDITURES

Under any of the alternatives described under Section IV, the Department also recommends the Legislature consider the following changes to the State Medical program which would require additional legislative action:

- Implementation of a resource test for the State Medical program which matches the Medicaid program resource test, i.e., $2,000 for an individual.

- Place a $100,000 ceiling on the amount that State Medical will reimburse for a single episode.

- Denial of State Medical eligibility for medical services arising from motor vehicle accidents when insurance coverage should have been available. Benefits would not be paid if medical insurance could have been purchased, but was waived.

- Elimination of State Medical program eligibility for students of higher education <u>when</u> the institution offers health insurance coverage and the student signs a disclaimer that they have other insurance or sufficient resources to meet medical needs.

- Recommend to the Legislature that a fee be collected on all motor vehicle insurance policies to be put into a fund to pay for medical services arising from motor vehicle accidents.

- Adopt a retrospective income assessment procedure to determine income eligibility rather than the current prospective system. A retrospective system would improve the department's ability to predict future recipient income.